State of New Hampshire
Board of Pharmacy
57 Regional Drive
Concord, NH 03301-8518
Tel.: (603) 271-2350 Fax: (603) 271-2856
Website: www.nh.gov/pharmacy/

REGISTRATION FEE:
$300.
Submit with Check or Money Order Payable To:
Treasurer, State of New Hampshire

NON-RESIDENT / MAIL-ORDER PHARMACY APPLICATION FOR PERMIT
APRIL 1, 2013 – MARCH 31, 2014 REGISTRATION PERIOD

☐ Check here if this application is being submitted as part of a ***change of ownership*** for a current NH registered mail-order pharmacy. If so, enter current NH Registration # **NR** _____

Pharmacy Name		
Pharmacy Street Address		
City	State	Zip Code

Direct Telephone Line To Pharmacist (For Board Inquiries)	Pharmacy Fax Number	Toll-Free Phone Number For Use By NH Residents
( )	( )	( )

Pharmacy E-Mail Address *(Must be entered in order to receive your permit)*	Pharmacy Web Page Address

Nature of Business: ☐ Retail Pharmacy ☐ Closed Door Pharmacy (Not Open to Public) ☐ Call Center ☐ Central Rx Processing ☐ Central Fill ☐ Other *(Describe):* _____

Name Of Pharmacist-In-Charge	Pharmacist License Number	State Of Issue

Pharmacy Hours
Monday -Friday (Open – Close): Saturday (Open – Close): Sunday (Open – Close):

Hours Toll-Free Telephone Service Is Available
Monday -Friday (Open – Close): Saturday (Open – Close): Sunday (Open – Close):

Type Of Ownership

☐ Individual Owner/Trustee/Receivership ☐ Partnership ☐ Corporation / LLC ⇒ *State Of Incorporation*:

Name Of Parent Company / Corporation / Owner	Telephone Number

Corporate / Owner's Mailing Address

* If a Corporation, attach a copy of the *Certificate of Incorporation (NOT Articles of Incorporation)* from the State Where Company is Incorporated.	* If a Corp., Limited Liability Company (LLC), Partnership, or Sole Proprietorship, Enter You Federal Tax ID#: _____

Types of Prescription Items Being Shipped To New Hampshire Residents

☐ Non-Controlled Drugs ☐ Controlled Drugs **Please Attach DEA Reg.* ☐ Prescription Devices
☐ Non-Sterile Compounded Products ☐ Sterile Compounded Products ☐ Other *(Describe):* _____

List Name, Address, & Title Of Corporate Officers, Partners Or Owner(s) – Or If Necessary, Provide As An Attachment

Name	Address	Title

Has the license/registration of this pharmacy ever been suspended, revoked, denied, voluntarily surrendered, placed on probation, or otherwise disciplined by any state or federal licensing/regulatory board/agency? ☐ Yes* ☐ No
*If yes, please attach explanation.

Has any of this applicant's owners, corporate officers, partners or pharmacists been found guilty of any felony in connection with the practice of pharmacy or distribution of drugs? ☐ **Yes*** ☐ **No** *If yes, please attach explanation.

Is the pharmacy owned by any individual licensed to prescribe medicine, or does any prescriber (or a prescriber's immediate family member) have a majority/controlling interest in the pharmacy? ☐ Yes * ☐ No

* If yes, what percentage of the pharmacy/corporation is owned by a prescriber or a prescriber's immediate family member? _____%

APPLICATION CONTINUED ON OTHER SIDE

Have any of the applicant's owners, corporate officers, partners or pharmacists been found guilty of any violation of federal, state, or local drug law or have entered into any agreement to resolve such violations? ☐ **Yes*** ☐ **No**
*If yes, please attach explanation.

Does the pharmacy have comprehensive liability insurance coverage? ☐ **Yes*** ☐ **No**

ATTACHMENTS: (ALL REQUIRED ATTACHMENTS MUST BE SUBMITTED OR YOUR APPLICATION WILL BE REJECTED)

As Pharmacist-In-Charge, please confirm/check the following, sign/date this application, and staple attachments to form:

☐ 1. A list of any and all internet websites from which the mail-order pharmacy solicits business;

☐ 2. A prescription label, containing the name, address and phone number of the pharmacy, that would be used on finished prescription products mailed to New Hampshire residents;

☐ 3. One of the following (A [Copy of current VIPPS Certificate from NABP] **or** B [All 4 items listed under B]):

A. Verified Internet Pharmacy Practice Site™ (VIPPS) accreditation from the National Association of Boards of Pharmacy; OR

B. The following materials:

1. At least 2 different photographs of the actual existing exterior, including the pharmacy signage, of the building in which the pharmacy will be or is currently located;
2. At least 2 different photographs of the prescription department as viewed by an approaching patron;
3. At least 4 different photographs of the prescription department as viewed from the interior, showing the prescription compounding area, refrigerator, water facilities, and pharmaceutical inventory storage area; and
4. Scaled drawings of the pharmacy and drug storage area (which must include square footage).

☐ 4. A sample copy of a patient medication profile / nightly prescription print-out / drug utilization review report, that shall include the following information:

A. Name and address of patient;
B. Name, address and DEA registration number of the prescriber;
C. Name, strength and quantity of drug dispersed;
D. Assigned prescription number;
E. Date of original filling; and
F. Date of refill(s).

☐ 5. A copy of the pharmacy's current license/registration issued by the Board of Pharmacy or other state regulatory agency where the pharmacy is located (home state), a copy of the pharmacy's state controlled substance registration (if applicable), and a copy of your current Federal DEA Registration Certificate (if shipping controlled drugs).

☐ 6. A copy of the pharmacy's most recent * pharmacy inspection report issued by the FDA, DEA, NABP, or State Board of Pharmacy where the pharmacy is located (home state) **Must have been within the past 18 months – if not, attach explanation. Your application may be held up until a more recent inspection is made.*

☐ 7. Attach a chart / diagram showing corporate ownership structure, including levels / percentages of ownership.

I, _____, certify that the contents of this application are true and correct to the best of my knowledge and belief.
Pharmacist-In-Charge (Printed Name)

Signature: _____ Date: _____

➔ THIS APPLICATION WILL NOT BE ACCEPTED WITHOUT A SIGNATURE AND DATE OF COMPLETION AND WITHOUT ALL REQUIRED ATTACHMENTS.

➔ NO PRESCRIPTION PRODUCTS CAN BE SHIPPED INTO NEW HAMPSHIRE UNTIL A NON-RESIDENT PHARMACY HAS BEEN DULY REGISTERED BY THE BOARD AND NO REGISTRATION SHALL BE GRANTED UNTIL A COMPLETE APPLICATION AND ALL FEES ARE PAID IN FULL.

➔ THE NEW HAMPSHIRE LAWS / REGULATIONS REGARDING NON-RESIDENT / MAIL-ORDER PHARMACIES SHIPPING PRESCRIPTION PRODUCTS TO NEW HAMPSHIRE RESIDENTS CAN BE FOUND ONLINE AT: www.nh.gov/pharmacy/laws/documents/mophcy_laws_rules.pdf